

**ADMINISTRATIVE SUMMARY OF INVESTIGATION
BY THE VA OFFICE OF INSPECTOR GENERAL
IN RESPONSE TO ALLEGATIONS
REGARDING PATIENT WAIT TIMES**



**VA Medical Center in Temple, Texas
December 20, 2016**

1. Summary of Why the Investigation Was Initiated

The Department of Veterans Affairs (VA) Office of Inspector General's (OIG) South Central Field Office, Criminal Investigations Division, in Dallas, TX, received allegations that employees of the Central Texas Veterans Health Care System (CTVHCS), Olin E. Teague VA Medical Center (OTVAMC), in Temple, TX, were "gaming" the appointment system, which led to prolonged wait times for patients, and as a result of these gaming practices, patient care had been negatively affected.

It was further alleged that CTVHCS leadership was aware of these gaming strategies being used from 2011 through at least May 8, 2014, but failed to properly correct the issue(s). It was alleged that employees continued to "game" the appointment system by scheduling patients for an appointment without first contacting the patients to properly determine a "desired date."

It was also alleged that CTVHCS leadership in the Executive Career Field and Senior Executive Service (SES) received larger bonuses than they might have otherwise earned due to the intentional manipulation of the appointment system.

VA OIG Office of Healthcare Inspections (OHI), in Dallas, TX, conducted an inspection at OTVAMC regarding an allegation of patient care delays and reusable medical equipment involving the Gastroenterology (GI) Clinic. OHI detailed its findings in a January 6, 2012, report¹ that found schedulers in the GI Clinic at the hospital were entering the incorrect patient desired dates for appointments. This specific issue was then tracked by OHI because the report recommended that the medical center director ensure that all staff follow VA policy for scheduling outpatient appointments and that compliance be monitored. The facility reported back to OHI that they had conducted monthly scheduled audits for the period October 2012 through November 2013 and the overall outcome met the target of 95 percent. In addition, the facility reported that the findings were submitted monthly to the Medical Staff Executive Council and the Executive Leadership Board.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed 40 employees, including the director, supervisors, and schedulers.
- **Records Reviewed:** VA OIG reviewed the annual performance appraisals of both the current and former directors for fiscal years (FYs) 2011, 2012, and 2013. Data related to

¹ [Report No. 11-03941-61](#), *Healthcare Inspection: Select Patient Care Delays and Reusable Medical Equipment Review Central Texas Veterans Health Care System Temple, Texas*

appointment scheduling for appointments occurring in the second and third quarter of FY 2014 were also reviewed.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- A scheduling trainer explained how he trained new hires and existing schedulers throughout CTVHCS. He said that every new Medical Administration Service (MAS) employee goes through the training and receives a copy of the scheduling standard operating procedure. He said that each employee signs off on attending the training and his/her supervisor signs off that the employee has completed the training. He stated that there were about 160–180 employees in MAS who scheduled appointments but did not know how many non-MAS employees scheduled appointments. He also stated that he was told by the director, associate director, and an assistant service chief to visit every Community Based Outpatient Clinic under the control of CTVHCS, to reiterate and reemphasize VA's policy on the use of desired dates and how to use VA's Electronic Wait List (EWL).
- A service chief described VA's scheduling process and explained the different dates that are calculated in the appointment process, including create date, desired date, and appointment date. She said there were about 600 employees able to schedule an appointment. She stated that VA OIG had previously conducted a review of the OTVAMC regarding scheduling allegations (the OHI inspection in 2012). She further stated that she had been interviewed during the previous VA OIG review. Although she was uncertain about when VA OIG visited, she stated that the VA OIG review was documented in a report. She also was uncertain which facilities in CTVHCS the VA OIG had reviewed. She stated that, after the review, the OTVAMC retrained its scheduling staff regarding processes and procedures for scheduling. She added that no one instructed schedulers to manipulate veterans' appointment desired dates or wait times.
- A VA employee who had earlier reported that appointment times were being altered to provide supervisors with monetary bonuses and to aid in career progression was interviewed. The employee stated that he thought things were better now and that management was taking steps to correct previous problems. He did not believe that the old process of scheduling was ongoing.
- A nurse manager stated that near the end of 2011, gaming of wait times was noticed within the hospital. She said that an OTVAMC employee thought it was employees not understanding the scheduling process and began retraining more than 90 percent of schedulers, along with conducting scheduling audits.
- A staff assistant stated that "access" (meaning access to care or the availability of appointments) was only a portion of approximately 60 or 70 measures and that access was not a "make or break" performance measure. He never heard the former director tell anyone to game the system and did not believe he ever would. He recalled that a service chief did some training about scheduling and access, and that scheduling audits were also

conducted and documented. Shortly after the incident at VA's hospital in Phoenix,² the director immediately held meetings with the service chiefs to determine if VA Medical Center (VAMC) Temple had the same issues.

- A non-clinical service chief stated that, for a while, the Systems Redesign coordinator would run a report for the director's weekly report. The service chief explained that the report focused on appointments falling outside of performance measures; it was never intended to tell clerks how to alter data. She stated that she never heard of, or received, an email telling schedulers to schedule a certain way to meet numbers. She said the director himself had over 600 individual contacts with schedulers to get feedback. She did not believe that meeting or failing access requirements would change a performance rating.
- An assistant service chief stated that the Austin Outpatient Clinic (AOPC) scheduling staff was not trained properly. He added that he was not aware of anyone who had instructed AOPC schedulers to manipulate patient wait times. He reviewed the historical data for AOPC and noticed that schedulers were not properly scheduling; he also noted that there were AOPC schedulers who were not asking patients for their desired date. He stated that some AOPC schedulers were scheduling patients on the first available appointment rather than having a discussion with the patients. He did not believe that AOPC schedulers were properly trained in scheduling before OTVMC MAS staff took over in 2013.

He said that he could provide more information about MAS schedulers and how MAS employees were trained; however, he could not talk about the other services' schedulers, who make up 68 percent of the scheduling staff. He stated that at OTVMC, 735 individuals had scheduling keys. MAS was responsible for 236 of those individuals.

He added that the EWL was not used because MAS staff always believed there was access; had he known there were access issues, he would have used the EWL. He reflected that it was unfortunate that individuals believed the EWL could not be used for any reason.

- A supervisory medical support assistant stated that she researched VA directives in 2011 and knew the rules associated with scheduling and that she followed the scheduling directive. She explained that there was a time when the desired date was being recorded as the first available date, while still taking into account the provider's orders.

She further stated that the scheduler would let the patients know what the first available appointment was and, if they agreed, that date would be recorded as the desired date. She denied ever instructing her schedulers to manipulate patient wait times. She stated that the scheduling policy was very confusing and that, unlike the Austin OPC scheduling staff, the OTVAMC scheduling staff was very seasoned. She believed that many schedulers who made mistakes were not intentionally manipulating wait times, but rather were making mistakes because they were scheduling too quickly.

² Any reference to Phoenix in this summary refers to wait time allegations that surfaced at VAMC Phoenix in early 2014.

- Twenty-six schedulers from different services and clinics were interviewed. These individuals were selected from data provided by the chief health informatics officer; his role was to identify employees who scheduled appointments and/or had scheduling keys at OTVAMC. The data also included the total number of appointments made by each individual; calculated wait times for Wait Time 1 and Wait Time 2; and percentages of wait times that were 0 days, less than 14 days, and more than 14 days. Of the 26 employees interviewed, 14 stated that at some point they had scheduled an appointment for a veteran using the “next available” function in the Veterans Information Systems and Technology Architecture (VistA), or used the next available appointment date as the veteran’s desired date in VistA. The remaining 12 scheduling employees said they did not use the next available function in VistA, or did not deviate from the scheduling directive when making an appointment for a veteran. None of the employees were aware of any OTVAMC employee, supervisor, or manager getting a bonus based upon shorter appointment wait times, which were obtained as a result of inappropriate scheduling practices or gaming strategies.
- Four OTVAMC supervisors and one patient representative from the AOPC were interviewed about their knowledge of scheduling practices. None of the supervisors was aware of any OTVAMC employee, supervisor, or manager getting a bonus based on shorter appointment wait times and obtained as a result of inappropriate scheduling practices or gaming strategies. The representative stated that he did not think schedulers were knowingly scheduling improperly.
- The director, CTVHCS, stated that her performance standards, as well as those of other VAMC directors, consisted of five critical elements. Element 5 includes wait times, but wait times is a very small portion of the element. There are numerous other measurements, other than wait times, that are part of Element 5. She stated that a director can fail the wait times goal but still pass Element 5. She further stated that she had yet to receive a performance rating for 2014 as the director of CTVHCS, nor had she received any bonus award as the director of CTVHCS. She denied manipulating wait time data in order to meet the VA’s 14-day goal. She said she has never instructed supervisors or their subordinates to manipulate wait times.

Records Reviewed

- On February 18, 2015, VA OIG Data Management staff obtained and analyzed data related to appointment scheduling—specifically, the period between the desired date and the appointment date for appointments occurring in the second and third quarters of FY 2014 for VAMC Temple. The data were divided into individual reports reflecting: percentage of scheduled appointments when the desired date was equal to the appointment date, percentage of scheduled appointments when the scheduled date was within 7 days of the desired date, and percentage of scheduled appointments when the scheduled date was within 14 days of the desired date. Of significance, over 95 percent of all scheduled appointments were reported as being scheduled within the 14-day period of the veteran’s desired date.

- The annual performance appraisals for both the current and former directors were reviewed for FYs 2011, 2012, and 2013, along with their performance bonus awards. Both directors were rated using measurements, criteria, and/or priorities as outlined in the Executive Career Field (ECF) Performance Plan and/or the Senior Executive Performance Plan, which were developed by the Veterans Health Administration (VHA). Based on a review of the performance appraisals, “access measurement” did not appear to be weighted any more or less than any other performance measurement cited, and subsequently used, as justification for either the current or former director’s performance bonus awards.

4. Conclusion

The investigation did not substantiate the allegation that either the current or former director encouraged and/or directed any employees to intentionally manipulate VA’s scheduling appointment system in an effort to receive larger performance bonuses than they would have otherwise earned.

None of the employees interviewed were aware of any OTVAMC employee, supervisor, or manager getting a bonus based on shorter appointment wait times that were obtained because of inappropriate scheduling practices or gaming strategies.

One employee noted that near the end of 2011, gaming of wait times was noticed in the hospital and the information was used to conduct retraining for employees who scheduled appointments, along with conducting monthly performance audits through chart reviews.

It was determined that some employees who scheduled appointments did not follow proper procedures based on the scheduling directive in place at the time.

Based on interviews of some schedulers, it was a recurring theme that consistent, thorough, and periodic training was desired and needed by the scheduling employees. Unlike the other services, MAS had an established training curriculum with a designated trainer. The trainer for MAS did not routinely train schedulers outside of MAS. MAS is responsible for providing the scheduling “keys,” which allows an employee to schedule appointments in VistA, but MAS does not routinely provide other support to non-MAS schedulers.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on February 27, 2016.



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